IN THE MATTER OF THE ARBITRATION BETWEEN

ST. MARKS LUTHERAN HOME	)	**FMCS NO.07-0316**
"EMPLOYER"	)	
And	)	**DECISION AND AWARD**
UNITED FOOD AND COMMERCIAL WORKERS UNION LOCAL 789	)	**RICHARD R. ANDERSON ARBITRATOR**
"UNION"	)	**AUGUST 9, 2007**

APPEARANCES

For the Employer:

Scott Allan, Senior Labor Relations Consultant
Tim Samuelson, Administrator
Kathleen Earl, Director of Nursing
Bonnie Thoreson, Human Resource Director
Heather Rysavy, Activities Director
Ercie Angell. CNA/Trained Medical Technician
Alisha Gwil, CNA/Trained Medical Technician

For the Union:

Roger J. Jensen, Attorney
Cathy Kelly, Grievant/Licensed Practical Nurse
Mary Nystrom, Licensed Practical Nurse/Charge Nurse
Mindy Ohm, Licensed Practical Nurse/Charge Nurse
Jennifer Christensen, Business Agent

JURISDICTION

The hearing in above matter was conducted before Arbitrator Richard R. Anderson on June 8, 2007[1] in Austin, Minnesota. Both parties were afforded a full and fair opportunity to present its case. Witness testimony was sworn and subject to cross-examination. Exhibits were introduced and received into the record. The hearing closed on June 8th. Post-Hearing Briefs were simultaneously mailed on July 17th and received on July 19th. The record was then closed and the matter was taken under advisement.

This matter is submitted to the undersigned pursuant to the terms of the parties' collective bargaining agreement that was effective from July 2, 2005 through July 1, 2007.[2] The language in Article 10 [GRIEVANCE AND ARBITRATION] provides for the filing, processing and arbitration of a grievance. Section 10.3 of this Article defines the jurisdiction of the Arbitrator, and Section 10.4 establishes the Arbitrator's sole decision-making authority. The parties stipulated that there were no procedural issues involved herein, and the matter was properly before the undersigned for final and binding decision.

BACKGROUND

The Employer is a long term, rehabilitation and transitional health care center located in the city of Austin, Minnesota. The Union represents all full-time and regular part-time Licensed Practical Nurses (LPN's). The bargaining unit, which consists of

[1] Unless otherwise indicated herein, all dates are in the year 2007.
[2] Joint Exhibit No. 1

approximately 25 employees, is set forth in Article 2 [RECOGNITION OF UNION]. The parties have a history of collective bargaining dating back to 1990.

On February 2nd, the Director of Nursing (DON) Kathleen Earl suspended the Grievant, Cathy Kelly, for three days for the period February 2nd through February 5th. The reasons for the disciplinary action are contained in the Notice Of Disciplinary Action (NDA) form that DON Earl issued to the Grievant that same day. The NDA, which the Grievant signed, stated:[3]

> *1/26/07 Was observed by two staff members giving insulin injections to a resident in the living room during an activity. Did not follow Post Fall management Protocal (sic) – 0 (zero) Neuro's completed or documented. Ongoing investigation pertaining to any or all above mention R/T incidents that occurred 1/27/07 during the Night Shift. investigation list attached.*

The attached investigation list stated:

> *Internal Investigation regarding incidents that occurred on 1-27-07 involving a resident on wing 3:*
>
> *1-26-07: Violation of ST Marks Medication Administration policy/procedure*
>
> *1-27-0 7: Staff Directed by DON to have a 1:1 for resident*
> *The Resident had 2 falls while he was suppose to be on 1:1*
> *Statements that 1:1 did not occur*
> *Statements from staff expressing concern of verbal abuse and neglect towards the resident involved*
> *Violation of St Marks Post fall management protocal (sic)*
> *Inconsistent documentation*
> *Violation of Threat to harm self protocal (sic)*
> *Violation of Nurse Practice Act*

The Union through Secretary/Treasurer Jennifer Christensen filed a grievance on February 6th protesting the three-day suspension, stating that the Employer "*may only suspend for 'just cause' (Section 9.1.1)".*

[3] Joint Exhibit No. 3A.

The Grievant was put on administrative leave after her suspension was served. Thereafter on March 6th, the Grievant was discharged pursuant to the Employer's progressive disciplinary policy. The NDA issued by Earl, that the Grievant refused to sign, stated:[4]

> *Cathy did not follow physician's orders on January 28, 2007. Cathy did not follow Pain Management Policy/Procedure on January 28, 2007.*

Secretary/Treasurer Christensen filed a grievance on March 7, 2007 protesting the Grievant's termination. The grievance stated:[5]

> *The Union hereby protests the termination of Cathy Kelly on March 6, 2007; as per the Collective Bargaining Agreement, employees may only be terminated for "just cause" (Section 9.1). The Union amends the grievance filed February 6, 2007 to include both the unjust suspension and unjust termination of Ms. Kelly.*

The parties were unable to resolve the grievance and the Union filed for arbitration with the Federal Mediation and Conciliation Service (FMCS).[6] The undersigned was notified of being selected as the neutral Arbitrator by letter from Secretary/Treasurer Christensen dated March 20.

THE ISSUE

The parties stipulated that the issue was, "Whether the Employer suspended and then discharged the Grievant, Cathy Kelly, for just cause, and if not, what is an appropriate remedy?

[4] Joint Exhibit No. 3B
[5] Joint Exhibit No. 2B
[6] The exact dates of the aforementioned activites are unknown.

RELEVANT CONTRACT PROVISIONS

ARTICLE 2- RECOGNITION OF UNION

2.1. Sole Representative

The Employer recognizes the Union as the sole and exclusive representative for the purposes of collective bargaining with respect to the hours of labor, rates of pay and working conditions herein specified, of all full-time and regular part-time Licensed Practical Nurses employed by Employer at its nursing home located at 400 15th Ave SW, Austin Minnesota, excluding all office clerical employees, managers, guards and supervisors as defined by the National Labor Relations Act.

ARTICLE 9- TERMINATION OF EMPLOYMENT

9.1. Discipline, Suspension, Demotion or Discharge

9.1.1. *Employees may be suspended, demoted or discharged for just cause. No grievance relating to any disciplinary action shall be valid unless submitted to the Employer in writing within ten (10) days after the discipline, suspension, demotion or discharge in question. All Licensed Practical nurses are expected to abide by the policies and procedures of St. Mark's Lutheran Home. Failure to comply with such policies will lead to disciplinary action in accordance with St. Mark's Lutheran Home Disciplinary Process. In the case of discharge, the employee affected may request and shall receive from the Employer in writing the reason for said dismissal.*

9.1.2. *Records of disciplinary action will remain valid for the purposes of evaluations and progressive discipline for no more than twelve (12) months* with the exception of when an employee reaches the point of suspension. In the event an employee has been suspended for any reason, that employee's suspension will remain valid in their personnel record for a period of eighteen (18) months.

ARTICLE 9: GRIEVANCE AND ARBITRATION

10.1. Grievances *Any dispute relating to the interpretation of or adherence to the terms and provisions of this Agreement shall be handled in accordance with the following procedures.*

10.3. Arbitrator Limitation *The authority of the arbitrator shall be limited to making an award relating to the interpretation of or adherence to the written provisions of this Agreement, and the arbitrator shall have no authority to add to, subtract from, or modify in any manner the terms and provisions of this Agreement. The award of the arbitrator shall be confined to the issues raised in the written grievance, and the arbitrator shall have no power to decide any other issue.*

10.4. Thirty Day Award *The arbitrator shall make a good faith effort to issue an award within thirty (30) calendar days following the close of the hearing. The award of the arbitrator shall be final and binding upon the Employer, Union, and employees involved. The fees and expenses of the neutral arbitrator shall be divided equally between the Employer and the Union*.

FACTS

The Grievant has been a LPN for approximately 25 years. She began her employment as a full-time LPN with the Employer in 1990. For the last eight years of her employment, she was the Union Steward. The Grievant was also involved as a preceptor since that program was formalized during the last one and one-half years of her employment. There were also six other preceptors. As preceptors, it is their responsibility to mentor and train new Nurses in their job duties and in the Employer's policies and procedures.

The Employer has a policy on the administration of medications that requires Nurses to provide privacy when giving injections. The Medication Administration Policy specifically states that injections "ARE NOT TO BE ADMINISTERED IN CONGREGATE OR PUBLIC AREAS".[7]

DON Earl testified that this medication administration policy was well known to the Grievant as well as other staff members especially since the Employer had gone to great lengths to tighten up the policy since State inspectors had recently cited the Employer for certain deficiencies. One of the deficiencies was for a Nurse giving injections in public areas, which the State inspectors had actually witnessed. As a

[7] Employer Exhibit No. 1

result the Employer stated that it began to tighten up its insulin injection policy/procedure.

According to DON Earl, she mentioned the insulin injection privacy policy in Nurses' meetings and also in e-mails to the Nurses. In this regard, the Employer introduced Exhibit No. 2, which was an e-mail from DON Earl to all Nurses dated November 2, 2006. The e-mail stated, "*Reminder: Residents are not to have accuchecks or injections in the common areas, this includes the hall way and dining areas*". The Employer also introduced Exhibit No.3, which was a packet of protocol instructions discussed at Nurses' meetings on March 2nd and 9th in 2006. The packet contained specific instructions (p. 11) about giving insulin injections in private areas of the facility. DON Earl, who put together the information packet, testified she specifically discussed this privacy policy for insulin injections in those meetings.

Activities Director (AD) Heather Rysavy testified that on January 26th, she was in the living room, which is a large meeting area for residents, families and volunteers, where a party was in progress and pizza was being served to residents. She stated that she observed the Grievant come into the room with a syringe in her hand. The Grievant proceeded to go over to a resident, lift up her shirt and administer an insulin injection to the resident's stomach area. AD Rysavy stated that she was approximately two feet away form the Grievant and the resident when she observed this conduct. She further stated that the only words she heard were uttered by the resident who said, "What are you going to do?", and then "Ouch, that hurts."

AD Rysavy further testified that she was surprised by the Grievant's actions. She has, however, observed other nurses giving insulin injections to residents in public

areas of the facility.[8] When she observed this, she usually reported it to upper management. She said that she was very familiar with the Employer's policy that insulin injections are to be given to residents in a private setting, since DON Earl repeatedly goes over this policy in monthly staff meetings and in e-mail transmissions.

The Employer has a four-step progressive disciplinary policy: This policy is reflected on the NDA form.[9]

> *(1) Reprimand and warning that additional infraction(s) will lead to further disciplinary action which may include suspension and dismissal.*
> *(2) Reprimand and warning that additional infraction(s) will lead to further disciplinary action which may include suspension or dismissal.*
> *(3) Warning: Suspension for ____working days, from ____(date) through ____ (date). Additional infraction will lead to dismissal of employment.*
> *(4) Warning: Dismissal of employment for additional infraction.*

There is also a 5th provision in the NDA for "*Immediate Dismissal*".

As stated earlier, the Grievant received a three-day suspension on February 2nd for misconduct on January 27th. DON Earl, Administrator Tim Samuelson and Human Resource (HRM) Director Bonnie Thoreson all testified that the Grievant was only being disciplined for the insulin injection infraction even though the NDA discussed other Grievant misconduct involving a resident who had recently fallen. They also testified that the Grievant was given a three-day suspension for the insulin injection incident because she was at the suspension stage in the Employer's progressive disciplinary policy. She was also put on paid administrative leave pending the outcome of the investigation.

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[8] During cross-examination, she stated that she did not know how many times she has observed it, but it could have been done as many as 20 times by as many as 20 different Nurses. During re-direct, she testified that she probably observed this activity once a month, however, in the last six months it has diminished due to the Employer emphasizing it during meetings.

[9] Employer Exhibit 3 A & B.

The Grievant had two disciplinary actions prior to her suspension, none of which were grieved. On March 8, 2006, DON Earl issued the Grievant a NDA involving a reprimand and warning, which the Grievant signed.[10] The NDA stated that the Grievant failed to do narcotics counts at the beginning and end of her shift. She also did not complete an every day dressing change. On December 28, 2006, the Grievant was issued another reprimand and warning, which the Grievant disputed. DON Earl issued the NDA by because the Grievant instructed a TMA (Trained Medical Technician) to give insulin injections to two residents. The Grievant response in the NDA stated that a TMA had drawn up insulin, but it was disposed of. She then drew up her own insulin and gave the residents their injections.

DON Earl further testified that when she is made aware of a violation of the insulin injection policy she takes appropriate action. The Nurse involved in the incident reported by the State inspectors received a verbal non-disciplinary counseling. This action was appropriate because the Nurse was a new employee without any previous discipline.[11] HRM Bonnie Thoreson, who has been in that position since 2003 and in Human Resources since 1995, testified that she is aware of all discipline that is meted out. She could only recall two incidents where Nurses were "disciplined" for giving injections in public areas. Both occurred after DON Earl's meeting with Nurses in March 2006. Both Nurses received non- disciplinary counseling for their infractions.

The Grievant in her testimony stated that when confronted by DON Earl, she did not deny giving a resident an insulin injection in a public area, however, she could not recall

[10] Joint Exhibits 3 A & B
[11] Counseling is not a discipline under the Employer's progressive disciplinary policy.

the specific incident for which she was being disciplined. She further testified that if a resident is due for an insulin injection it is important that they receive it especially if they are going to be eating. She acknowledged the Employer's policy on not giving insulin injections in public areas. However, when a resident refuses to go back to their room or another private area, they have no authority to force the resident to go anywhere, and must then give the injection in public areas. When this happens, they try to make it as private as possible and shield the resident with their body.

Union witnesses Charge Nurse/LPN Mary Nystrom and Charge Nurse/LPN Mindy Ohm, both of whom are long-term employees, testified that if they are required to give an insulin injection to a resident and the resident refuses to go to their room, they have no alternative but to give the injection in public areas. They added, that forcing a resident to go to their room would violate the rights of the resident. When they do this, they try to screen the resident with their body to make the injection as private as possible.

In the meeting where the Grievant was suspended and received the NDA, DON Earl informed her that she would be investigating her conduct surrounding the care of the resident who had fallen, taken to the emergency room and returned to the nursing home.[12] DON Earl testified that during the internal investigation a dozen witnesses were interviewed including the Grievant twice. As a result of the investigation, the Grievant was discharged on March 6th for failing to follow physician's orders and not following proper pain management on January 28th involving a resident who had injured

[12] Secretary/Treasurer Christensen testified that she attended this meeting via telephone and nothing was said about a further investigation. Evidence suggests that she left the meeting before it was completed.

himself earlier that morning. Prior to her discharge, the Grievant had served her three-day suspension and was on paid administrative leave until March 3rd.

The evidence discloses that a resident with dementia had a history of incidents related to falls. He had also exhibited episodes of atypical behavior and threatened suicide.[13] The latest series of these incidents occurred on the evening of January 27th and the morning of the 28th. Prior to the Grievant beginning her 11:00 p.m. shift, an LPN noted in her chart notes that at 9:00 p.m. the resident had placed a call light cord around his neck.[14] The police were notified and came to the facility at which time the resident was sent by ambulance to the local hospital emergency room. According to the chart notes of the Grievant, the resident returned to the facility at approximately 11:18 p.m.[15] Upon his return, the resident was very agitated and was swearing and yelling. At 11:58 p.m., the resident stripped from the waist down and voided in a tissue, began throwing cookies, coffee cups, his portable call light on the floor and accused the staff of stealing. He had displayed similar behavior in the past.

Shortly afterwards the resident had the first of his two falls. The chart notes prepared by the Grievant at 11:52 p.m. indicate the following happened:[16]

> *At 12:20 AM, resident was observed trying to stand from recliner. Observed him losing his balance and falling slowly toward left side. Curled up and fell underneath desk without hitting head. Able to move extremities without pain or crepitus. Has skin tear on left elbow that is approximately 0,5 cm in length. Was less than cooperative with cleansing and applying a band aid. Refused VS. Assisted to recliner with three staff as unable to put sling around resident to use mechanical device. Has been 1:1 with staff at bedside. Has threatened to "starve myself to death." In next breath demands food, but refuses when food offered. Staff had been standing*

[13] Union Exhibit No. 4
[14] Employer Exhibit No. 9-1
[15] Employer Exhibit No. 9-2
[16] Id.

outside door so that resident could be observed without further agitating him, He has been sexually inappropriate in his comments. Continues to sit naked from the waist down. Hitting and kicking at staff.

The resident had another fall approximately one-half hour later, which resulted in him being transported to the local hospital emergency room and returned to the facility after being treated. According to the Grievant's charting notes, the following transpired:[17]

At 1:15 AM, resident has been 1:1 with staff. Stood up and required 2 assist to get him in a safe position. Assisted to recliner after putting pants on hint, He requested "something to eat. " Aide left resident for less than two minutes to get him a sandwich. Upon return, resident was discovered lying on his left side in front of recliner. Chair was still recliner because resident was unable to reach the controls, Large pool of blood on floor. Refused to allow this writer to get a good look at wound. Ice applied as resident would allow. Call placed to AMC and received order to send for evaluation by Dr, Barsourn. Call placed to Steve Thorson to inform. Left at 1:45 AM via ambulance. Had been grimacing when he turned himself. Was placed on a back board with a C collar prior to leaving.

Returned at 3:45 AM. Wound on head cleaned. Treatment to use ice per wound sheet. Offered twice and refused. At 4:15 AM refused VS. PEARL. AROM good.[18] Hitting and kicking at staff. 1:1 with staff. At 5:15 AM, refused VS, but did allow pupil check. PEARL. Has been picking at wound to. "I want it to bleed." Has refused to use walker when walking. Either walking without device or using over bed table.

The emergency room doctor's Clinical Report found that the resident had a skin laceration to his scalp during a fall.[19] There was "*No numbness, dizziness, loss of vision, hearing loss or chest pain*". Also, "*No difficulty in breathing, weakness, nausea, abdominal pain or* vomiting". The resident did, however, complain of lower back and

[17] Employer Exhibit No. 9-3
[18] VS are vital signs. PEARL (PERRL) means pupils equal round reacted to light and is used to determine neuro symptoms. AROM is active range of motion.
[19] Employer E No. 7.

neck pain. The doctor's Discharge Instructions that were issued for the resident are as follows,[20]

Single contusion with abrasion to the head.

The examination and treatment you have received in the Emergency Department have been rendered on an emergency basis only and are not intended to be a substitute for or an effort to provide complete medical care. Your own physician will have access to your record and all test reports. Because it is impossible to recognize and treat all elements of an injury or illness in a single Emergency Department visit, it is important that your physician check you again and that you report any new or remaining problems at that time. It is very important to carry through on your follow-up instructions and appointments so that you can achieve the best results from your treatment in the Emergency Department. Your x-rays and EKGs will be reviewed in detail by another physician. If the final report is different than the initial report, you will be notified.

ADDITIONAL INFORMATION

CONTUSION, SOFT TISSUE
You have a Contusion, which is a bruise with swelling and some bleeding under the skin. There are no broken bones. This injury takes a few days to a few weeks to heal.

Home Care:
1) Keep the injured part elevated to reduce pain and swelling. This is especially important during the first 48 hours.
2) Make an ice pack (ice cubes in a plastic bag, wrapped in a towel) and apply for 20 minutes every 1-2 hours the first day. Continue this 3-4 times a day until the swelling goes down.
3) You may take Tylenol (acetaminophen) or ibuprofen (Advil, Motrin) for pain, unless another pain medicine was prescribed.

Follow up with your doctor or this facility if you are not improving within the next three days. [Note; If X-rays were taken, they will be reviewed by a radiologist. You will be notified of any new findings that may affect your care.] Return promptly or contact your doctor if any of the following occur:
Pain or swelling increases
Injured arm or leg becomes cold, blue, numb or tingly
Redness, warmth or drainage from the skin
Fever over 99.5 (oral)

The charting notes for the remainder of January 28th indicate that the resident had ceased his atypical behavior, was not agitated and was very cooperative with the

[20] Employer Exhibit No. 8.

nursing staff. The notes also indicated that the resident was in no pain and that his regular dosage of Tylenol was administered along with his other meds at noon. There is no indication in the notes that a pain assessment was done or that the resident received ice pack treatment.

The Grievant testified that after the resident fell, she immediately tried to administer care to him; but he was unwillingly accept it. The only ice pack in the immediate area was large and hard. The CNA with her tried to apply the ice pack but the resident was unwilling to cooperate. She said she told the CNA to try to do the best she could, and proceeded to call the doctor at the emergency room and the resident's family. When the ambulance arrived she told the attendant that the patient was complaining about his back so they used a backboard when they transported him.

The Grievant stated that when the resident returned to her "wing" approximately two hours later, she tried to do vital signs (VS). She was alone at the time. She was not able to do blood pressure or pulse or respiratory checks, however, she was able to do a pupil (PEARL) check. She did the pupil check without using a flashlight because she did not want to agitate the resident any further than he already was. At this point, the resident in an agitated state said, "*he did not want to come back*". The Grievant then assisted the resident back to his room. While she was alone walking with the resident, she attempted to apply a 3" by 3" blue ice pack to the resident's head.[21] She was only able to apply it for a minute or two because the resident did not want it on him.

[21] She testified that she did not use a bigger ice pack because the only one available had been thrown away as it was very bloody.

When the resident returned to his room, she did not do a pain assessment. The Grievant stated that she had 24 hours to do a pain assessment per the Employer's policy/procedure. She was also feeling ill that night and was trying to get everything done, including getting the resident back into the room and trying to get all the paper work completed associated with his return as well as her care for 50 or 60 other residents. The Grievant added that there was no need to do a pain assessment at that time because the resident had just been treated by the emergency room doctor, who would have done it. Further, the resident was not complaining about pain nor did she observe any indications that the resident was in pain. The resident obviously was not in pain because he was engaging the CNA's in conversation and actually walked by himself using a small table as a walker from the room to the adjacent hallway and then sat in a recliner.

Finally, the Grievant testified that she did not give the resident any pain medication as prescribed by the doctor because he was not complaining of pain, and she observed that he was not exhibiting any pain symptoms. She testified that the doctor's instructions only required pain medication as needed. Based upon her observation of the resident, he did not ask for or need medication. In situations such as this, it is the Nurses' judgment whether to administer pain medication or not.

Employer witnesses Ercie Angell and Alisha Gwil, both CNA/Trained Medical Technicians, testified that they were working with the Grievant during her shift and neither aide ever saw the Grievant apply or attempt to apply an ice pack to the resident nor were they ever instructed to do so by the Grievant. CNA Angell testified that she was with the resident for approximately two and one-half hours and never left his side.

She stated that she never saw the Grievant examine the resident in any way even though the Grievant walked past her and the resident in the hallway. She also stated that the Grievant never said anything to her to about applying an ice pack to the resident's head even after she brought it to the Grievant's attention that the resident was picking his wound causing it to bleed. According to CNA Angell, the only comment made by the Grievant was "*I don't* care". CNA Gwil testified that after she replaced CNA Angell, she never saw the Grievant examine the resident nor was she instructed by her to do anything specifically for him.[22]

The Employer has a comprehensive pain management policy that includes pain assessment procedures. As a result of the State inspection in September 2006, the Employer received a "high" deficiency rating for incomplete pain assessments and improper pain management.[23] As a result, the Employer began to tighten up its pain assessments and pain management procedures as it had done with its insulin injection procedure. The Employer undertook extensive training concerning its pain management, pain assessment and pain evaluation policy.[24] According, to the Employer's policy, a pain assessment must be given for a new admission, or within 24 hours of a resident's return from the hospital, or if a resident complains of pain.[25]

Union witnesses Charge Nurse/LPN Mary Nystrom and Charge Nurse/LPN Mindy Ohm both testified that pain assessments are not done nor are pain assessment forms filled out when a resident returns from a hospital including its emergency room. In

[22] Gwil was on duty with the Grievant for approximately ½ hour.
[23] Employer Exhibit No. 16.
[24] These are the same training sessions mentioned in the discussion of the insulin injection policy training. Employer Exhibit No. 16, 20, 21 and 22.
[25] See also Union Exhibit No. 2, wherein the Grievant acknowledged this policy on April 8, 2002.

support of this, the Union furnished evidence that in 4 out of the 13 situations analyzed by the Union where falls were involved, Nurses did not do a pain assessment or fill out pain assessment forms. Also, the other Nurses who cared for the resident did not perform a pain assessment or fill out pain assessment forms during their shifts in the 24-hour period following the resident's return from the hospital.

Finally, The Employer filed a Vulnerable Adult report with the Mower County Department of Human Services as required by law on January 30th.[26] On February 1st, the Minnesota Department of Health requested information from the Employer concerning the fall of the resident including details of the Employer's investigation.[27] It is not known what information the Employer furnished, however, on February 23rd, the State notified the Employer that "*The information has been reviewed and it has been determined that no further action by this office is necessary at this time. However, the information has been referred to the Board of Nursing.*"[28] As of the date of the hearing, the Board of Nursing has neither taken any action nor informed the Grievant that there is an investigation pending regarding her conduct.

POSITION OF THE EMPLOYER

The Employer's position is that it did not suspend or discharge the Grievant in violation of the just cause standard in Section 9.1.1 of the Agreement. The Employer argues that it was justified in suspending the Grievant because she admittedly gave a resident an insulin injection in a public area where other residents were congregated and could observe the injection. This action by the Grievant violated the Employer's

[26] Employer Exhibit No. 12.
[27] Employer Exhibit No. 13.
[28] Employer Exhibit No. 14.

insulin injection privacy policy/procedure. The Grievant was well aware of the policy, which had been discussed many times in Nurses' meetings and various e-mails from DON Earl. The Grievant is a senior LPN. She is also a preceptor who is responsible to mentor and train newly hired Nurses in the Employer's policies and procedures, and thus is very familiar with the Employer's injection policies and procedures. There is also no contention or evidence that the Employer's injection policy/procedure is unreasonable.

The Employer also argues that it followed its progressive disciplinary policy when it meted out discipline to the Grievant. The Grievant had two prior disciplines during her last year of her employment. She was, therefore, at the third stage (suspension) of the progressive disciplinary policy.

The Employer further argues that it had just cause to discharge the Grievant for failing to follow the emergency room doctor's instructions, and for her failure to follow proper pain management protocols, since she was at the discharge stage in its progressive disciplinary policy. The Grievant was very familiar with the Employer's pain management policy. There is also no contention or evidence that the pain management policy is unreasonable. Post-fall pain assessment and evaluation is an important factor at the nursing home. This is evidenced by the amount of training DON Earl conducted in these areas and the importance of the issue as reflected in the State Survey.

The Employer argues that there is ample evidence that the Grievant failed to follow the doctor's discharge instructions for the injured resident. Specifically, the doctor's instructions were for the Grievant to, "*Make an ice pack (ice cubes in a plastic bag, wrapped in a towel) and apply for 20 minutes every 1-2 hours the first day. Continue*

this 3-4 times a day until the swelling goes down." There is credible evidence from CNA"s Angell and Gwil that the Grievant never applied an ice pack to the resident's head nor asked them to do so. It is unlikely that the Grievant could have held the ice pack while she was assisting the resident to his room following his return, as the Grievant testified.

There is also refutable evidence that the Grievant only had access to a 3" by 3" ice pack. CNA Angell testified that if there was a head wound, she would normally be told to apply a plastic bag of ice to the wound. She also testified that there were pre-made ice packs "*about half the size of a piece of paper*" available. Thus, it is apparent that if the Grievant used an ice pack at all, it was clearly larger than the ice pack the Grievant allegedly used. It is then reasonable to conclude that the larger ice pack would be cumbersome if it were administered to an agitated individual who was also being assisted in walking.

The Employer further argues that the Grievant admitted that she did not do a pain assessment of the resident when he returned from the emergency room. The Employer's pain management policy clearly requires a pain assessment or evaluation in this situation. The Grievant argued that she did not observe anything that would have led her to believe that the resident was in pain. Why would the doctor order ice pack treatment or prescribe medicine if the resident was not in pain. The Grievant's training provided her with signs that were readily apparent that night. The resident exhibited signs listed in the pain management policy such as "*awake all night*", "*change in the*

resident's mood or behavior" and had "*a condition* (head wound) *that commonly causes pain*".[29]

The Employer also argues that there is no basis to the Grievant's argument that the resident was too agitated to assess. While the resident was agitated, the Grievant and CNA Angell both testified that he was calmer with CNA Angell. The Grievant could have instructed CNA Angell to engage in pain management practices such as applying an ice pack, taking his vital signs, and administering Tylenol.

The Employer further argues that the Grievant also failed to chart any pain assessment even if she had allegedly done one. The Union, through a review of patient documents, tried to show the Grievant did nothing differently than other Nurses had done in the past. DON Earl pointed out, and the documents indicate, that the fundamental difference here is that the Grievant failed to document any pain assessment. This was precisely the issue that the State Survey addressed.

Finally, the Employer argues that the Grievants suspension was assessed only for the insulin injection incident. This was made clear to the Grievant at the meeting. It was also made clear that the Employer would be doing a further investigation concerning the Grievant's care associated with the fall of a resident on January 28th.

POSITION OF THE UNION

It is the Union's position that the Employer did not have just cause pursuant to Section 9.1.1 of the Agreement to suspend or discharge the Grievant. The Union argues that the Grievant gave an insulin injection to a resident in the living room after the resident refused to go to her room for the injection. When the Grievant gave the

[29] Employer Exhibit 20, p.13.

injection, she attempted to give the resident privacy by screening the resident with her body. Testimony from the Grievant and other Union witnesses as well as Employer witness AD Rysavy clearly show that this same procedure has been followed by numerous Nurses, and no Nurse has ever been disciplined. HRM Thoreson and DON Earl both testified that only two other Nurses have been confronted about giving injections in public areas. Neither were ever disciplined, rather they were given non-disciplinary verbal counseling.

The Union argues further that the Grievant did not engage in any conduct that warranted a just cause discharge. With regard to the Grievant's failure to do a pain assessment either before or after he returned from the emergency room, the evidence shows that she did a pain assessment and based upon that assessment sent the resident to the emergency room. Thereafter, the emergency room doctor evaluated the resident and, therefore, it was not necessary to do another pain assessment when the resident returned. If it was necessary, according to the Employer's own policy, she had 24 hours to do so. It is also important to point out that none of the other Nurses who relieved her did a pain assessment within the 24-hour time period. If they did, it was not charted.

During cross-examination, DON Earl acknowledged that only Registered Nurses (RN's) may assess for pain. Thus, the Union argues how could the Grievant be disciplined for not doing a pain assessment when by definition the Grievant was not qualified to assess. When DON Earl was asked what was the Grievant supposed to do regarding pain management policy, she replied the Grievant should have evaluated the resident by looking at the wound, asking him if he was in pain and then documenting

her action on the her charting report. DON Earl added that those actions were not charted; therefore, they never happened.

The evidence submitted by the Union disclosed that in at least four other situations where falls were involved, no pain assessment or evaluation was recorded. In other situations pain assessments or pain evaluations were not immediately given upon a resident's return from the emergency room.

The Union also argues that the Grievant's testimony and her notes reflect that she tried to place an ice pack on the resident's wound, but the resident fought her off. With regard to the allegation that she failed to give the resident medication prescribed by the doctor, the Grievant testified that she observed nothing that would indicate that the resident continued to experience pain. The doctor's instructions on medication were permissive with regard to medication, only if the resident experienced pain. That is the way the Grievant interpreted them.

The Union also argues that the Grievant's discharge for the events surrounding this resident constitutes double jeopardy. The suspension NDA clearly discloses that the Grievant was suspended for violating the Employer's insulin injection privacy policy and, "*Did not follow Post Fall Management Protocal* (sic) *– 0 (zero) Neuro's completed or documented"*. Thereafter, the Grievant was discharged for some of the same conduct for which she was suspended.

The Union also argues that progressive discipline is designed to give an employee an opportunity to correct behavior. Since she never went back to work following her suspension, she did not have an opportunity to correct her alleged misconduct involving

alleged improprieties associated with the resident's care, which was the subject of both her suspension and discharge.

The Union also argues that there has been no allegation that the Grievant's conduct involving the resident's care in and of it self justified discharge. The NDA clearly states she was being discharged because she was at the 4th step of the Employer's disciplinary policy and not for "*Immediate Dismissal*", an option on the form.

Finally, the Union argues that the State did not find any merit to the Vulnerable Adult complaint filed against the Grievant, which supports her case that she did not do anything wrong. This notification to the Employer came before the Grievant was discharged. The fact that the Board of Nursing has not taken any action against the Grievant suggests that the Grievant did not do anything wrong.

OPINION

The issue before the undersigned is whether the Employer had just cause pursuant to Section 9.1.1 to suspend and then discharge the Grievant. This issue presents a well-settled two-step analysis: first, whether the Grievant engaged in activity which gave the Employer just and proper cause to discipline her; and second, whether the discipline imposed was appropriate under all the relevant circumstances. It is the Employer's burden to show that the Grievant engaged in conduct warranting discipline and that the appropriate disciplines were suspension and termination.

The Employer has a four-step progressive disciplinary policy. It imposed the penalty of discharge pursuant to this policy based on the Grievant's disciplinary history. This policy appears to be unilaterally imposed since there is no evidence that it was the subject of negotiations or was ever adopted by the Union. Rather, the parties have

negotiated strict "just cause" language in Section 9.1.1 of the Agreement. Absent just cause language, the burden on the Employer would be to establish that the conduct engaged in by the Grievant justified discipline and that the discipline warranted a Step 3 suspension because the Grievant had previously occupied Step 2 (2nd reprimand) of its progressive disciplinary policy; and whether the subsequent discipline warranted a Step 4 discharge because the Grievant had previously received a Step 3 suspension.

A progressive disciplinary policy, however, does not, per se, justify discharge. Such a perfunctory assessment of discipline is inconsistent with a negotiated just cause standard. When the Employer entered into the just cause standard in Section 9.1.1, it created more than a carte blanche right to suspend and then discharge the Grievant solely because of its progressive disciplinary policy. This is especially true in suspension and discharge cases. In these cases, a significant quantum of proof is required to show not only that a grievant engaged in the misconduct alleged, but also that the misconduct justified suspension and/or discharge.

In the matter at hand, it is whether the Grievant violated the Employer's policy by giving a resident an insulin injection in a public area that resulted in a three day suspension, and subsequently being discharged for failing to follow doctor's instructions and violating the Employer's pain management policy. The question then is does the Grievant's conduct, per se, satisfy the just cause standard warranting suspension and/or discharge because of its seriousness.

Although just cause has no universally accepted definition, arbitrators often determine the existence of just cause by applying the well-known “Seven Tests Standard". Arbitrator Daugherty in Grief Brothers Cooperage, 42 LA 555, first articulated these tests.

558 (1964).[30] In these cases Professor Daugherty notes that a negative answer to any of these questions may well mean that there is insufficient cause for the discipline imposed. These tests are as follows:

1. Did the Company give to the employee forewarning or foreknowledge of the possible consequences of the employee's conduct?
2. Was the Company's rule or managerial order reasonably related to the orderly efficient and safe operation of the Company's business?
3. Did the Company before administering the discipline to the employee make an effort to discover whether the employee did in fact violate or disobey a rule or order of management?
4. Was the Company's investigation fair and objective?
5. At the investigation, did the "judge" obtain substantial evidence of proof that the employee was guilty as charged?
6. Has the Company applied its rules, orders and penalties evenhandedly and without discrimination to all employees?
7. Was the degree of discipline administered by the Company in a particular case reasonably related to (a) the seriousness of the employee's proven offense and (b) the record of the employee in his service with the Company?

When the particularized facts surrounding the Grievant's suspension are fully examined, it is apparent that a suspension is not an appropriate discipline. The evidence clearly shows that the Grievant gave a resident an insulin injection in a public area, and that this action is contrary to the Employer's policy. The evidence also shows that the Grievant's activity is not unusual. However, no Nurse has ever received discipline for violating this Employer policy. The evidence is also clear that this policy has been widely disseminated to the Grievant and other Nursing staff; however, neither the Grievant nor any other Nurse has ever been warned that a violation of this policy would result in discipline. If the Employer intended to formally begin disciplining Nurses for the same conduct that previously went undisciplined, it should have put them on notice.

[30] See also. Enterprise Wire Co., 46 LA 359 (Daugherty 1966).

The non-warning of possible disciplinary consequences and the disparate disciplinary action directed at the Grievant together mitigate against any strong discipline, much less suspension. It is, therefore, apparent that the Employer has failed to satisfy its "just cause" burden in leveling this harsh discipline at the Grievant.

The Employer is not contending that the alleged misconduct of the Grievant on the morning of January 28th was sufficiently egregious to warrant immediate discharge. It is solely relying on the fact that the Grievant's alleged misconduct moved her to the discharge step of its progressive disciplinary policy. Having failed to establish its burden vis-a-vis the Grievant's Step 3 suspension, it ipso facto removes the progressive penalty of discharge from the Employer's progressive disciplinary policy.

Even assuming arguendo that it did not, the Employer still failed to establish that it had just cause to discharge the Grievant. Even crediting the Employer that the Grievant failed to perform a pain assessment of the resident upon his return from the hospital emergency room and failed to follow the doctor's order by not applying an ice pack to the resident's head or administering Tylenol or ibuprofen to the resident, these actions do not rise to the level of work place capital punishment given all the circumstances present herein.

Even if she did not perform a pain assessment and/or record it, the evidence strongly indicates that other Nurses failed to perform similar pain assessments and/or record them and were not disciplined.[31] Also, the resident just returned from the

[31] Throughout the hearing the term pain assessment was used loosely. A pain assessment can only be performed by a Registered Nurse who is also responsible to fill out the pain assessment form. In most instances the parties were really talking about pain evaluations rather than formal pain assessments, which an LPN documents in her chart notes.

hospital emergency room where undoubtedly the doctor did a pain assessment of the resident.

With respect to the Grievant's failure to apply an ice pack to the injured resident's head, the Grievant claims that when she was alone with the resident, she attempted to apply an ice pack at least twice to the Grievant's head. Even if the Grievant is truthful in her remarks, she could have attempted to apply the ice pack once the resident calmed down or instructed one of the CNA"s to perform this task. The CNA"s testified that one of them was constantly in the room with the resident during the remainder of the Grievant's shift and none of those actions occurred. The Grievant's testimony does not dispute their testimony.

Regarding the Grievant's failure to administer pain medication to the resident, the Grievant said that, based upon her observations of the resident, he was not in pain nor did he indicate that he was in pain. Since the doctor's instructions on pain medications were discretionary, she made the decision not to administer any Tylenol or ibuprofen.

Additionally, there is no evidence to refute the Grievant's observations that the resident was in pain. If the resident had been in pain, the emergency room doctor would have administered pain medication at the time of his treatment and/or prescribed medication to be taken at a specific time, eg. once every three hours. The CNA"s working with the Grievant never testified that they observed the resident in pain nor did he ever indicated to them that he was in pain. In addition, the chart notes of the Nurses who relieved the Grievant are devoid of any mention that the resident was experiencing pain or that a pain medication was administered other than Tylenol during noon on the 28th as a part of the resident's regular medication regimen.

In conclusion, the evidence clearly shows that the Employer failed in its burden to establish that it had just cause to discharge the Grievant. Even assuming arguendo that some discipline was justified, the evidence clearly established that discharge was not the appropriate discipline for all of the reasons set forth herein.

AWARD

IT IS HEREBY ORDERED that the grievance in the above entitled matter be and is hereby sustained for the reasons set forth in this Decision.

IT IS FURTHER ORDERED the suspension and discharge of Cathy Kelly be rescinded; and any reference to the suspension or discharge be expunged from her personnel file, consistent with my Decision herein.

IT IS FURTHER ORDERED that Cathy Kelly be reinstated to her former position; and be made whole for any loss of wages, economic benefits, seniority, or any other benefits or rights or privileges suffered as a result of the Employer's action in suspending and subsequently discharging her, less any interim earnings.

The undersigned Arbitrator will retain jurisdiction in this matter for a period of forty-five (45) days from the receipt of this Award to resolve any matters relative to implementation.

Dated: August 9, 2007

Richard R. Anderson, Arbitrator